

CASp TEST ACCOMMODATION(S) REQUEST QUESTIONNAIRE

VOLUNTARY CERTIFIED ACCESS SPECIALIST (CASp) PROGRAM

This form may be completed online and printed. Please read the *ADA Test Accommodation(s) Guidelines for the CASp Examination (03/20/16)*, incorporated by reference, and the *CASp Examination, Certification, and Practice Standards Handbook (02/2016)*, incorporated by reference, before completing this CASp Test Accommodation(s) Request Questionnaire. Candidate information items with an asterisk (*) are required to be provided.

CANDIDATE INFORMATION				
Title:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Dr.
Name (Last)*	(First)*		(Middle)	
Mailing Address – Street address or PO Box *				
City*	County	State*	ZIP Code *	
Primary Phone*			Secondary Phone	
Email*				

What accommodation(s) appropriate to the disability are you requesting?

ACCOMMODATION REQUEST
Large empty area for accommodation request

CASp TEST ACCOMMODATIONS REQUEST QUESTIONNAIRE

To document your need for an accommodation as completely as possible, write a personal statement describing your disability and its impact on your ability to take the exam under standard conditions. Please indicate if your disability is permanent.

PERSONAL STATEMENT

REPEATED

I certify under penalty of perjury under the laws of the State of California that the information on this application is true and complete to the best of my knowledge. I acknowledge that any false, incomplete, or incorrect statements may result in my disqualification from the certification process or denial of my request for accommodation in taking the CASp examination.

SIGNATURE

DATE